ABILITY TO PAY – FEE ACTION REQUEST

ND Department of Human Services/Fiscal Administration
SFN 196 (02-05)

FILLED OUT BY INITIATOR OF REQUEST

Client Name:	Case Number:

Please check the appropriate box(es) below:

☐ Specific percent discount requested (complete information below)
Percent of discount _____ % (Based on sliding fee schedule) Effective Date ___/___/___
Review in ____ months (not to exceed 12 months or one year)
☐ Do NOT send to collections Review in ____ months (not to exceed 12 months or one year)
☐ Do NOT send statements Review in ____ months (not to exceed 12 months or one year)
☐ Other (specify) _____
Review in ____ months (not to exceed 12 months or one year)

Additional Discount Type:	***Financial Hardships: Monthly Income and Expenses must be completed for all Financial Hardships.**	
☐ Administrative Decision ☐ Countertherapeutic ☐ Financial Hardship* ☐ Income Deadline Missed	**Must Be Completed**	
	MONTHLY INCOME	MONTHLY EXPENSES
	TOTAL $0.00	TOTAL $0.00

Describe the uniqueness of the client's situation (please be specific): (You may attach additional sheets if necessary)

Impact on client if not approved:

For Business Office Use Only (To be completed before Unit Supervisor, Fiscal Manager, & Reg. Director signature is attained)

Original Discount %	Effective Date _____/_____/_____
Additional Discount %	Effective Date _____/_____/_____
Final Discount %	

Initiator of Request:	Date:
Unit Supervisor:	Date:
Regional HSC Fiscal Manager:	Date:
Regional Director:	Date:
Business Office Clerk:	Input Date: